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	005107	A. BUILDING: _____ B. WING _____	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ANTHONY HEALTH - CROWN POINT	1201 S MAIN ST CROWN POINT, IN 46307

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S 000	INITIAL COMMENTS This visit was for investigation of two State hospital complaints. Complaint Numbers: IN00142185: Substantiated with deficiency cited related to the allegations. Unrelated deficiency cited. IN00150018: Unsubstantiated; lack of sufficient evidence. Date: 10/30/14 Facility Number: 005107 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor QA: claughlin 01/06/15	S 000		
S 418	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2) (b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows: (1) The action shall be documented. (2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care.	S 418		

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S 418	Continued From page 1 This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, and interview, the hospital failed to ensure that an incident report was completed regarding an incorrectly dictated radiology report for 1 of 1 patients with an ovarian cyst diagnosis (Pt. #14). Findings: 1. Review of the policy "Incident Reporting", no policy number, last revised 5/29/13, indicated: a. Under "Key Points", it reads: "1. A reportable incident is: a. An undesirable event that is inconsistent with the routine care of the patient. b. An event that has the potential for injury or causes injury to a patient, visitor, workforce, or medical staff...". b. Under "Procedures", it reads: "...5. The Manager/Director will ensure the proper follow-up by the appropriate person(s). 6. Risk Management will monitor the data contained in the Incident Reports and collaborate with the Performance Improvement department for quality improvement activities so that care being provided can be evaluated." 2. Review of the medical record for pt. #14 indicated: a. A pelvic US (ultrasound) was done and dictated at 1:09 AM on 5/31/13 that indicated, in the "Impression" section of the report, "1. 7.3 cm left ovarian simple cyst. 2. No uterine mass or abnormal endometrial thickening." (The right ovary "measures 1.9 x 2 x 3 cm".) b. An US was performed on 5/31/13 and indicated dictation was at 12:27 PM, with the "Exam" type noted as "Ultrasound pelvis complete and transvaginal". c. The "Impression" read: "...2. Left ovary is within normal limits. 3. Right ovary is enlarged	S 418		

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and demonstrates a 5.5 cm sized cyst with small amount of free fluid adjacent to it, this is is (sic) slightly decreased in size compared to the previous ultrasound done earlier."

d. An "Addendum" to the 5/31/14 12:27 PM (dictated) US report was dictated at 8:56 AM on 1/27/14, with the note reading; "There is a mistake in the impression of the report. The body of the report is correct in terms of abnormal ovarian cyst present in the left ovary and the right ovary is normal. The correct impression should read as follows: "1. Uterus is within normal limits...2. Right ovary is within normal limits. 3. Left ovary is enlarged and demonstrates a cyst measuring 5.5 x 4.8 x 5.8 cm, with a small amount of free fluid adjacent to it, the cyst is slightly decreased in size compared to previous ultrasound of 5/30/2013."

e. At the end of the dictation in the addendum, it reads: "Ultrasound pelvis completed (transabdominal only)."

3. At 2:25 PM on 10/30/14, interview with staff member #64, the radiology manager, indicated:

a. This staff member recalls the confusion with pt. #14's ultrasound reports when a complaint was lodged at the facility on 10/8/13.

b. It is unclear why it took so long between 10/8/13 and 1/27/14 when the addendum was dictated.

c. A transvaginal pelvic ultrasound was ordered, but not done, per family request for this teen patient. A transabdominal ultrasound was completed, but the first (5/31/13) US report wrongly indicated that a transvaginal US was done.

d. It was thought that an incident report was completed due to the incorrect documentation of the first US, where a cyst was noted on the right ovary, when in fact, it was the left ovary.

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S 418	Continued From page 3 e. No incident report can be found related to the incorrect US report dictation. 4. At 2:45 PM on 10/30/14, interview with staff member #65, the director of customer service and satisfaction, indicated: a. The complaint related to pt. #14, was "closed" on 11/11/13, with no documentation, by this facility department, that the US report of 5/31/13 was dictated incorrectly and needed an addendum. 5. At 3:40 PM on 10/30/14, telephone interview with staff member #67, the regional director of risk management, indicated: a. This staff member requested that the radiologist review the 5/31/13 US readings for any error, to make the change/addendum as needed, and to "communicate with the family" the error in dictation/reading of the second US. b. An incident report would not need to have been completed if the error in reading the US was included in the investigation of the complaint lodged regarding pt. #14. c. If the error was included in the investigation, it would have gone to the quality committee in that reporting route, rather than as an incident report. d. Since there was nothing in the complaint investigation that indicated an US reading error had occurred, then, an incident report should have been completed by the radiology department regarding this. e. It is not clear what transpired between 11/11/13, when it was determined that the complaint for pt. #14 was closed, and 1/27/14, when an addendum was made to the second US radiology report, as documentation is lacking related to this.	S 418		

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S 418	Continued From page 4 6. At 4:00 PM on 10/30/14, interview with staff member #65, the director of customer service and satisfaction, indicated: a. This staff member is unaware of what transpired between November 11, 2013 and 1/27/14 when the addendum was dictated, other than the 11/13/13 letter sent to the family of pt. #14. (See c. below.) b. There is no documentation, that can be found, related to the information received from the telephone interview with staff member #67 that the radiologist was requested to review the US reports and "communicate with the family". (See 5. a. above.) c. The final letter sent to the family of pt. #14 was dated 11/13/13, and indicated: "...Radiologic studies showed: Ultrasound on May 30th, 2013 at 11:00 pm (sic) showed a simple 7.3cm left ovarian cyst with good blood flow to both ovaries. Repeat Pelvic Ultrasound on May 31st, 2013 at 11:00am (sic) showed a Right 5.5 cm ovarian cyst with some fluid around the ovary. The cyst was reported to have decreased in size and there was good blood flow to both ovaries...". 7. At 4:15 PM on 10/30/14, interview with staff member #60, a quality and risk staff member, indicated: a. The quality committee never reviewed an incident of radiology report error, related to pt. #14, as no report was generated and the incident was not part of any complaint/grievance report to the quality committee.	S 418		
S 912	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)	S 912		

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S 912	Continued From page 5 (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital. This RULE is not met as evidenced by: Based on policy and procedure review, medical record review, and interview, the nurse executive failed to ensure the implementation of the ED (emergency department) pain policy for 3 of 5 ED patients (Pts. #10, #12, and #14).	S 912		

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S 912	Continued From page 6 Findings: 1. Review of the policy "Pain Management in the ED", no policy number, last revised 2/12, indicated: a. Under "Procedure", it reads: "...b) Pain management will be offered at the time of triage, this will be documented and the physician notified so that medication can be given in a timely manner...2) All patients with pain will have regular reassessment. a) Pain scale will be documented at the time of triage and first intervention. It will be reassessed as appropriate to the route, dosage, and type of medication as well as age and condition of the patient. b) Pain reassessment will also be done periodically while the patient is in the department, based on condition, as well as at the time of discharge or admission to the hospital 3) If pain medication is delayed or held per physician discretion, this will be documented in the chart...". 2. Review of ED patient medical records indicated: a. Pt. #10 was admitted to the ED on 5/31/13 at 5:22 PM with abdominal pain and diarrhea and: A. Rated pain at a 10 (out of 10) at 5:40 PM in triage, but lacked documentation that pain management was offered at that time, per facility policy. (Triage began at 5:37 PM and ended at 5:42 PM.) B. Was placed in an ED room at 5:54 PM and given Toradol for pain, rated at 10, at 6:27 PM. C. Had no follow up to the 6:27 PM pain intervention until 8:22 PM when the patient rated their pain level at 9 in nursing notes and at 9 on the VS (vital signs) documentation section of the chart. b. Pt. #12 was seen in the ED on 6/1/13 with RLQ (right lower quadrant) pain with no	S 912		

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medications given while in the ED and documentation as follows:

A. Arrival to the ED as at 1:46 AM with triage beginning at 1:59 AM and ending at 2:10 AM.

B. Pain level in triage was 8 at 2:03 AM, with the chart lacking documentation that pain management was offered at that time, per facility policy.

C. The patient was placed in an ED room at 2:11 AM and the next documentation of pain notation was at 4:10 AM when the physician wrote "...resting comfortably..." and at 4:33 AM when nursing noted "Pt resting on cart [no] distress".

D. The patient went to the OR (operating room) for an appendectomy at 5:54 AM with no further documentation of a pain assessment, especially at the time of discharge, as required per facility policy.

c. Pt. #14:

A. Was admitted to the ED on 5/30/14 at 10:34 PM and scored for pain at a level of 7 (out of 10) at 10:48 PM per triage, but lacked documentation that pain management was offered at that time, as per facility policy.

B. Had a nursing note at 10:55 PM that indicated the patient: "C/o (complained of) pain in LLQ (left lower quadrant) with emesis x1 - pain radiates down lt (left) thigh Had mild soreness across upper back Earlier but pain is now gone..".

C. Was given Toradol 30 mg IV (intravenous) at 11:28 PM, with no pain level documented at the time of this intervention, and with no follow up notation of follow up pain reassessment after the medication was given.

D. Had the next documented pain level noted at 12:50 AM on 5/31/13, when the patient scored pain at 3 (out of 10).

E. Had a return visit to the ED on 5/31/13 with

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pain rated at 9 at 10:41 AM while in triage, but lacked documentation that pain management was offered at that time, per facility policy.

F. Was placed in an ED room at 11:11 AM where the nurse noted "...Pt states severe pain", but lacked a pain score at that time.

G. Was given Morphine 4 mg IV at 11:19 AM with no documentation of a pain score. Reassessment was at 11:35 AM when the patient rated pain at a 3.

3. At 1:35 PM on 10/30/14, interview with staff member #68, the RN (registered nurse) ED nurse manager, indicated:

a. If pain is the chief complaint for an ED patient, nursing staff should check/assess/reassess an ED patient "more frequently".

b. During new staff orientation, its discussed how often to assess/reassess patients for pain, and that every one to two hours is routine for patients while they are in the ED if their "chief complaint" is pain.

c. After administration of pain medications, such as Toradol IV, it would be expected, and per standards of practice, to reassess a patient's pain within 45 to 60 minutes.

d. Pt. #10 had an almost 2 hour time frame between 6:27 PM pain medication (Toradol IV) and reassessment at 8:22 PM, which is not per expectations.

e. Pt. #12 was admitted with pain at an 8 at 2:03 AM and lacked a reassessment by nursing until it was noted that the patient was resting on the cart in no distress at 4:33 AM.

f. Pt. #12 had no further documentation of a pain assessment after 4:33 AM, and no discharge pain score charted when discharged to the OR at 5:54 AM.